

## INITIAL APPLICATION

### California Radiology Supervisor and Operator Certificate

Last Name, suffix	First Name	Middle Name
Date of Birth	Social Security Number	Phone Number
Mailing Address		E-mail Address
City	State	ZIP Code

**It is very important that you provide your full true name.**

Pursuant to the authority found in Section 114870 of the California Health and Safety Code and as required by Section 17520 of the California Family Code, providing the social security number is mandatory. The social security number will be used for purposes of identification. The information on this form may be provided to federal, state, or local agencies for law enforcement purposes. This information may also be provided to the American Registry of Radiologic Technologist for examination purposes. For information or access to your records, contact the Chief of the Certification Unit at the California Department of Health Services, Radiologic Health Branch, MS 7610, P.O. Box 997414, Sacramento, CA 95899-7414, (916) 327-5106.

**Include with this application:**

- ☐ Your nonrefundable application fee payment in the form of a check or money order made payable to “CDHS-RHB” (*California Department of Health Services – Radiologic Health Branch*) for the amount of \$85.00.
- ☐ Documentary evidence that you are certified by the American Board of Radiology or the American Osteopathic Board of Radiology.
- ☐ If you are not Board certified, include a separate payment for testing fees in the amount of \$500 in the form of a cashier’s check or money order, payable to the “American Registry of Radiologic Technologists.” (*Personal checks will not be accepted.*)
- ☐ Documentary evidence that you have one of the following valid California healing arts licenses: Physician and Surgeon, Osteopathic Physician and Surgeon, Podiatrist, or Chiropractor.

Return this form along with payment and a copy of your California healing arts licenses and Board certificate to:

**Billing and Cashiering Unit  
California Department of Health Services  
Radiologic Health Branch, MS 7610  
P.O. Box 997414  
Sacramento, CA 95899-7414**

*I certify that all information provided with this application is true and correct. I understand that the California Department of Health Services may cancel certificates that are procured by fraud, misrepresentation, or mistake, and may revoke certificates for the nonpayment of fees. Further, I am aware that it is unlawful to use X-rays on human beings in this state unless I am certified pursuant to the Radiologic Technology Act and I am acting within the scope of that certification.*

Signature	Date
-----------	------